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No-Fault Medical Injury Compensation: Hoofbeats or Pipe Dreams?

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BOOK REVIEW

NO-FAULT MEDICAL INJURY COMPENSATION: HOOFBEATS OR PIPE DREAMS?

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A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION. By *Paul C. Weiler, Howard H. Haitt, Joseph P. Newhouse, William G. Johnson, Troyen A. Brennan,* and *Lucian L. Leape.* Cambridge: Harvard University Press. 1993. Pp. xiv, 175.

INTRODUCTION

In 1984 a group of physicians, law professors, and researchers from Harvard University began exploring the array of problems associated with medical injuries and malpractice litigation, and considering proposals for reforming the current tort system (p. vii). When the Harvard Medical Practice Study Group began its exploration, the only other major study on the incidence of medical injuries was one completed in California in the mid-1970s (p. viii). Although considered ground breaking, the California study failed to address some of the major problems in the area and was deemed to have limited value in the current debate on malpractice litigation and reform (p. viii). The Harvard group formulated a plan for a more comprehensive study to confront the major facets of the malpractice debate: the nature and incidence of medical in-

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juries, patient losses and the degree to which such losses are compensated from nontort sources, the practical availability of the tort system to injured patients, and the impact of malpractice litigation on physician behavior, including the extent to which such litigation deters patient injury (p. viii).

The Harvard group first offered its proposal to state officials in Massachusetts but received a tepid response (pp. viii-ix). At the time, the Massachusetts Legislature was debating the merits of medical malpractice damage caps, stricter disciplinary measures for doctors, and various other tort reform proposals (p. ix). Consequently, the proposal was rejected for fear that it might derail the legislative process then underway (p. ix).

The State of New York, however, was receptive to the Harvard group's proposal. In 1986, with the support of Governor Mario M. Cuomo's Commissioner of Health, Dr. David Axelrod, the Harvard group was commissioned to conduct a three-year study at a cost of approximately four million dollars (p. ix). The group endeavored to determine the number of patients injured in hospitals, the proportion of those injuries that were caused by negligence, the number of patients who brought lawsuits, and the extent to which the lawsuits had merit (p. ix). Further, the Harvard group sought to determine the extent of financial loss suffered by the injured patients, the sufficiency of "alternative sources of compensation," and the deterrent effect of malpractice litigation on doctors' professional behavior and on the risk of injury to patients (p. x).

The comprehensive nature of the Harvard Medical Practice Study required that the researchers amass and analyze a staggering amount of information. As a result, the study took six years to complete. In order to ensure an accurate statistical representation, the researchers reviewed 30,000 patients' hospital records from fifty-one acute-care nonpsychiatric hospitals (p. x). They also interviewed 2500 patients and surveyed 1000 doctors. Lastly, they analyzed and reviewed the files relating to nearly 70,000 medical malpractice claims made in the State of New York between 1975 and 1989.[1] *A Measure of Malpractice: Medical Injury,*

[1] The authors note that the information required for the study could only be gathered with the assistance of the participating hospitals and staff (p. x). The cooperation of the hospitals and staff was secured by promises that no patient would be advised that an injury had occurred or had resulted from negligence (p. xi). Without such a guarantee, the group felt certain that the hospitals would have denied access to their records (p. xi). On the other hand, extending these confidentiality guarantees

Malpractice Litigation, and Patient Compensation summarizes the Harvard group's findings and proposals, and its justifications for the reforms suggested.

Parts I through VII of this review critically examine the book's conclusions regarding the adoption of a no-fault system to replace the present tort system. Part VIII examines the shortcomings of the no-fault system, and suggests that the medical malpractice crisis under the present tort system is not quite as critical as the authors assert. Finally, although the learned authors of this book will surely be called upon for their expertise in the broader policy debate on health care, this review suggests that the authors' no-fault system should not be adopted.

I. THE BACKGROUND OF THE STUDY

The authors maintain that the recent clash between the tort system and the medical profession is, in part, the result of two medical malpractice insurance premium crises in two decades and the fear of a third such crisis (pp. 1-3). The skyrocketing premiums of the mid-70s and mid-80s were primarily responsible for the birth of the so-called "tort reform movement" (pp. 2, 6-7).[2] Furthermore, although the authors concede that erratic premiums are primarily attributable to the special characteristics of liability insurance, they assert that the long-term trend of inflated medical malpractice premiums is the result of the steadily rising cost of medical liability itself (pp. 3-4).

Two variables ultimately determine premium levels: claim frequency and claim severity. "Claim frequency" refers to the number of claims filed against health care providers in a given period of time while "claim severity" refers to the average payment made on successful claims. In the late 1950s, claim frequency was only one claim per 100 physicians per year, while in the latter part of the 1980s more than ten claims per 100 physicians were filed each year. Similarly, the average payment per

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to the hospitals raises ethical questions about patients' rights to full disclosure (p. xii). The researchers' concern about the ethical implications of the guarantees was eased, however, when the Human Subjects Committee of the Harvard School of Public Health approved the practice of concealing information from study subjects (p. xiii).

[2] In the mid-1970s the first malpractice crisis resulted in the doubling of insurance premiums in three years. In the aftermath of a legislative stabilization effort premiums leveled off, but a second crisis arose in the 1980s causing a second doubling of insurance premiums within a three year period (p. 3).

successful claim increased from $40,000 in 1970 (adjusted to 1990 values) to almost $150,000 by the end of the 1980s (p. 4).

The special characteristic of medical malpractice insurance that helped to send medical malpractice premiums spiralling upward, in contrast to other types of liability insurance, is, as the authors referred to it, the longer "tail" of medical malpractice insurance coverage (pp. 4-5). This tail represents the length of time between an injury, the filing of a claim, and the claim's disposition.[3] This tail forced insurance carriers to use premiums paid in later years to defend claims that had been incurred years earlier. Losses were therefore higher than the insurers had forecasted, which necessitated the increase of premiums to cover the shortfall.

The insurance industry responded to this perceived malpractice crisis with a three-pronged plan: changes in the liability insurance system, "tort reform," and improvements in the quality of health care. The liability insurance system authorized insurance companies to begin writing "claims made" coverage policies instead of the usual "occurrence" policies (p. 7). The claims made coverage protected physicians for the period in which the claims were made irrespective of when the treatment was rendered or when the injury occurred. These new policies made it easier for insurers to formulate a premium payment schedule that more accurately forecasted the time claim payout was required, thereby eliminating the underwriting problems caused by delayed claims (p. 7). Furthermore, patient compensation funds were created to relieve the burden on individual doctors by requiring the hospital where an injury occurred to "channel" the personal liability of the doctor through the institution's insurance policy (p. 8).[4] In order to fill the void created by insurance companies that had fled the market, companies owned by and insuring only physicians, so-called "bedpan mutuals," and joint underwriting associations were created (p. 7). Additionally, two states now require merit rating of malpractice insurance so that doctors with higher rates of claims asserted against them or paid on their behalf will pay higher premiums (p. 10).

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[3] "In the nation as a whole, the *median* time from injury to claim is 13 months, and from claim to payment 23 months, for a total of three years." (p. 5) (emphasis in original).

[4] These patient compensation funds are either maintained by all providers in the state or by the state's taxpayers (p. 10).

Reform of medical malpractice litigation was directed primarily at limiting claimants' access to the courts and appraising the merits of an injured patient's legal claim on a legal standard of care defined to be considerably more favorable to doctors than to other tort defendants. To achieve these goals, fixed dollar caps were set to limit the amount of an injured's award, and payment of such damages were made over time, as the losses occurred. Furthermore, payments were terminated if the injured did not survive as long as was anticipated (pp. 8-9).[5] In addition, this statutory reform included a shortening of statutes of limitations, mandatory presuit screening, and a reduction of contingent fees allowed to be charged by an attorney to pursue a claim with a risky prospect for recovery.

To foster better quality health care, hospitals, health care organizations, and state health departments have been required to adopt measures aimed at improving staff conduct and the monitoring of patient complaints (p. 10).

Against this background of rapid change and legislative experimentation, the Harvard group conducted its study and proposed alternatives to the then existing tort system. As evidenced by available empirical studies completed prior to the Harvard Medical Practice Study, many of the laws enacted to modify patient accessibility to the courts and the liability of health care providers had a mere modest effect on lowering insurance premiums (p. 11).[6] The authors maintain that the most effective measure for lowering premiums and costs was to cap damages (pp. 10-11). This approach, however, shifts the burden of containing malpractice costs from doctors to the one class of individuals least able to afford it, namely, the patients who suffer the most severe injuries and, therefore, have the greatest financial needs (p. 11). The authors contend that the most alarming problem with capping damage awards is that legislators have assumed that malpractice litigation is an evil without first balancing the benefits provided to patients with the heavy burden malpractice litigation places on the legal system (pp. 11-12).

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[5] New York does not allow an injured victim's award to be constrained by a monetary ceiling, but it does, however, "authoriz[e] judges to review and revise any award that appear[s] to 'deviate materially from what would be reasonable compensation for the case.'" (p. 9).

[6] *But cf.* Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims*, 49 LAW & CONTEMP. PROB. 57 (1986) (noting that most tort reform legislation has provided relief sought by medical profession and insurance industry).

II. The Argument Against the Tort System

Professor Weiler and his colleagues evaluate the tort system's effectiveness and its alternatives by comparing and contrasting three major categories: compensation to injured victims, the expense of administering the system, and the system's effectiveness in preventing future negligent medical care (pp. 14-19).

The authors contend that they properly avoided focusing solely on the two major objectives of the tort system—loss shifting to the culpable party, or "corrective justice," and the deterrence of future negligence (pp. 15-16). Asserting that these objectives have become more theoretical than real in today's medical malpractice litigation, since insurance companies, and not doctors, inevitably compensate injured patients, the authors maintain that their analysis is the more pragmatic and appropriate approach to the debate. The Harvard group focused on the way injured patients are compensated and the economic effect of the tort system, as well as its effectiveness in preventing substandard medical treatment so that all patients may be protected from medical malpractice injuries (pp. 16-19).

The tort system is perceived as arbitrary and unfair because it is designed to compensate only those losses suffered by patients who can prove that they have incurred iatrogenic injuries from substandard medical care, while it neglects injured patients with equal needs, whose injuries did not result, or cannot be proven to have resulted, from medical malpractice (p. 16). The system is further criticized as "incompatible with sound principles of loss insurance" since awards are granted for intangible damages, such as pain and suffering, and loss of consortium (p. 16). Similarly, the authors view the system as flawed because it permits "full replacement of all lost earnings or treatment costs without any application of the deductible or coinsurance formulas that are standard in both private and public insurance" (p. 16). This view is outdated and simplistic. At the time of publication of this book there were few, if any, states in this country without collateral source set-off statutes covering benefits paid by insurance. The authors also overlooked the need for requiring an injured patient to prove negligence before any damages are recovered, and the fact that a share of the patient's recovery goes to pay the contingent fee of plaintiff's counsel since in most malpractice cases plaintiffs cannot recover attorney's fees from a negligent defendant (p. 16).

The authors then attack the administrative burden imposed by the tort system. They agree with other critics of the tort system that it is too expensive to administer since proving fault often necessitates incurring the high costs associated with litigation. They also attack the administration of the current tort system by asserting that its reliability is hampered by jurors who are unable to assess complex medical standards of care (p. 17). Although the authors indicate their disdain for the abilities of jurors throughout the book, no empirical data are ever offered to justify their position. The need for expert witness testimony to guide lay jurors is viewed as a primary cause of high administrative costs in medical malpractice cases. Ironically, the authors concede that only approximately forty percent of the total administrative costs in malpractice claims ever reaches the patients to compensate them for their injuries (p. 17).

Recognizing the viewpoints of critics of the tort system, the authors suggest two reasons behind the system's failure to deter future negligent medical care or improve the quality of medicine (pp. 17-18). First, they state that the monetary "penalty" imposed on a negligent doctor depends on the fortuitous occurrence and severity of the patient's injuries, rather than on the doctor's culpability.[7] Second, they assert that the system actually encourages unnecessary and wasteful modes of defensive medicine to reduce the potential for the filing of a claim, rather than deterring the incidence of iatrogenic injuries from occurring in the first instance (pp. 17-19).

The authors offer two possible alternatives to "tort-fault liability": a "no-liability" approach or a "no-fault (or strict) liability" option (p. 19). Advocates of the "no-liability" approach suggest doing away with tort liability and providing redress for injured patients through options similar to those that are available to victims of any other disabling injury resulting from causes other than medical treatment. These advocates envision "considerably improved systems of social insurance for medical costs and lost earnings, and stiffer regulatory sanctions against risky behavior" (p. 19). Alternatively, "no-fault (strict) liability" would entitle an

[7] Under this approach, an extremely negligent doctor whose malpractice does not cause serious injury may escape liability, while a doctor whose negligence causes grave injury, even if he is generally a careful physician, may be held liable for millions of dollars in tort damages, since an attorney is more likely to make the substantial investment required to maintain an action against the physician (pp. 17-18).

injured patient to compensation regardless of whether medical malpractice was involved (p. 19). Such a system, which is favored by Professor Weiler and his colleagues, would be funded by medical accident insurance provided on a mandatory or volunteer basis by private or public insurance carriers. Responsibility for adverse consequences "would still be discharged through a special program devised and paid for within the health care system" (p. 19).

The authors believe that the no-fault plan would better compensate the victims of all medical injuries, as it eliminates the element of "luck" associated with attempting to prove medical malpractice (p. 20). Additionally, they state that the plan is "more in accord with sound insurance principles" (p. 21) because, although it would decrease compensation for lost earnings and intangible damages, such as pain and suffering and loss of the capacity for the enjoyment of life, the system would compensate all medical injury victims, and not only those whose injuries were caused by negligence (pp. 20-21).

The authors also speculate that the savings which could be realized by eliminating the need to prove negligence could enable a large amount of societal resources presently spent on lawyers, expert witnesses, and court costs to be spent reimbursing injured patients for their losses (p. 21). The only issues that would arise under the proposed no-fault system would be whether the patient had, in fact, suffered a medical injury and the extent to which such injury should be compensated. The manner in which these issues would be resolved, by whom, and why they would not be as contentious as causation and damage claims in tort cases are not topics the book examines in any detail.[8]

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[8] Elsewhere, one of the book's authors has described in greater detail the administration he envisions for the no-fault system:

> A mature system might function similarly to the system now existing in Sweden. A patient who was medically injured would be assisted in filling out a claims form by a social worker. An adjuster employed by the hospital's liability insurer would review the claim. If it merited further attention, the adjuster would confer with an insurance company physician, and they would put together an offer for the patient that would be subject to approval by a claims board at the company. If the patient did not find the offer acceptable, she could appeal to an appeals board operated by the state . . . . Further appeal could then be made to an intermediate level state court, based on an "arbitrary and capricious" standard.

Troyen A. Brennan, *Improving the Quality of Medical Care: A Critical Evaluation of the Major Proposals*, 10 YALE L. & POL'Y REV. 431, 458 (1992). *See generally* MARILYN M. ROSENTHAL, DEALING WITH MEDICAL MALPRACTICE: THE BRITISH AND SWEDISH EXPERIENCE 174-83 (1988) (describing Swedish no-fault system in greater detail).

Finally, the authors consider the no-fault system's ability to deter future iatrogenic injuries, and thereby improve general health care, slightly superior to the present tort system (pp. 20-21). In addition to confining legal responsibility for injuries in the medical care system, the proposed no-fault system would compensate patients' losses due to unavoidable iatrogenic injuries (p. 22). The net effect of this coverage would provide "the health care system [with] a powerful incentive to develop innovative quality assurance techniques and equipment that would make it feasible to avoid more and more of the medical accident toll" (p. 22).

Although the authors mention several problems critical to acceptance of their proposal, they do not persuasively resolve them (pp. 22-32). First, the Medical Insurance Feasibility Study in California in the mid-1970s found a disabling injury risk rate of one in every twenty hospital admissions.[9] Because only a small fraction of those injuries ever resulted in actual tort recoveries, serious doubt arises over the way a no-fault plan could feasibly compensate all medical injuries without severely limiting the level of compensation.[10] Second, the authors concede that proponents of no-fault are uncertain how "injuries," unexpected adverse events that result from medical care (recoverable under no-fault), may be successfully distinguished from those conditions that are the natural consequences of medical care (not recoverable under no-fault). Thus, determining the extent to which a medical injury is compensable may prove to be just as difficult to accomplish in the no-fault context as it is in the current tort system. This possibility, coupled with the greater number of claims that no-fault would entail, raises doubt about whether there would be sufficient savings in administration and litigation expenses to adequately fund a no-fault plan (p. 24).

A third concern is the impact the no-fault scheme would have on the incentives for safe treatment (pp. 24-25). The authors acknowledge that, although under a no-fault system all patient injuries would be covered, the damages awarded to patients who are the victims of negligent treatment would undoubtedly be less than those provided under the current tort system (p. 24). Thus, "the financial incentive to avoid *negligent* incidents . . . would be significantly reduced" (p. 24). In addition, under the proposed plan, in-

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9 *See* CALIFORNIA MEDICAL ASSOCIATION, MEDICAL INSURANCE FEASIBILITY STUDY (Donald H. Mills ed., 1977).

10 *See id.* A no-fault system could, in fact, increase insurance premiums. *Id.*

surance would be provided and paid for by hospitals, clinics, HMOs and other health care organizations, rather than the individual physicians who provide the treatment and cause the injury (p. 24). Consequently, society would be stripped of a deterrent mechanism for substandard medical care. More importantly, under a no-fault plan there would be no trials to subject doctors and hospitals to public scrutiny and promote safer treatment. Ironically, even the patient's responsibility for exercising care in following a treatment regimen might be reduced under no-fault, since a guarantee of compensation might reduce a patient's tendency to exercise care with regard to his or her condition (p. 25). While the tort system can be said to encourage the practice of defensive medicine, a no-fault system may actually increase this practice, particularly with respect to hospitals. Hospitals could potentially reduce their financial exposure to liability costs by refusing high risk patients (those whose treatment is most likely to result in medical injury and a subsequent claim), leaving them with limited treatment options (p. 25).

In the final analysis, the authors conclude that a no-fault compensation plan is, or can be made, financially affordable (pp. 27-29). Although the authors acknowledge that insurance premiums could increase significantly under the Harvard group's proposed plan, they contend that there are ways to keep costs down. For instance, limits could be placed on the extent of coverage by accounting for alternative sources of compensation when determining how much of an injured patient's losses to compensate (p. 28). In addition, priority may be given to "the longer-lasting disabilities that affect far fewer patients but inflict severe or even catastrophic losses on the individual and family concerned," while short-term disabilities and minor losses "can and should be covered by the victim's personal resources" (p. 29).

The authors claim that a no-fault liability system, if it functions like workers' compensation, should be preferable to malpractice litigation since in a workers' compensation system only twenty percent of each dollar is applied to administration expenses, which is one-third of the comparable costs expended in connection with medical malpractice cases.[11]

The Harvard group concludes its comparison of the relative merits of a tort-based system versus a no-fault plan by asserting

[11] Later in the text, the authors concede that the savings enjoyed under a no-fault system may not be as great as those enjoyed under workers' compensation (p. 106).

that it began its work without an affirmative position on the superiority of one over the other (p. 149). Rather, the authors' primary objective was to gather empirical data so that informed judgments could be made about proposals for changing the tort system. Although one may question the viability of their proposals for change, the study results themselves are both fascinating and enlightening. The authors' efforts to gather useful information have proven to be eminently successful.

III. THE INCIDENCE OF MEDICAL INJURY, ITS CAUSES AND VICTIMS

The Harvard researchers had three stated objectives. First, they wanted to obtain accurate information on the incidence and pattern of medical injuries in New York hospitals and on the medical settings in which they occurred (p. 33). Second, they sought to determine whether the tort system functioned effectively in compensating patients and deterring future injury. Finally, the authors needed information to achieve perhaps their "most important[ ] objective of helping to develop a comprehensive methodology for preventing medical injury" (p. 33).

To achieve these goals, researchers reviewed 31,000 medical records from patient admissions in fifty-one New York nonpsychiatric hospitals in 1984 to identify iatrogenic medical injuries (adverse events) and to determine if they were due to negligence.[12] The book defines adverse events as "the unintended or unexpected harmful consequences of medical intervention . . . that prolonged the hospitalization beyond the time required by the underlying illness and/or caused disability at the time of hospital discharge or death" (p. 35). A negligent medical injury is defined as one resulting from care that did not meet "the standard of the average medical practitioner in the field" (p. 35).

To ensure the accuracy of its study, the Harvard group trained medical record analysts to scrutinize all records for evidence of one or more of eighteen clinical criteria frequently associ-

[12] The Harvard group deferred to the California study, a review of 20,000 medical records conducted in 1974, as a model (pp. 33-34). The California study revealed that an adverse event occurred in 4.65% of hospitalizations, roughly one for every 21 admissions (p. 36). The incidence of adverse events due to negligence was 0.79% of admissions, or one in 125. Of the total number of adverse events in California in 1974, one in six was deemed caused by negligence (p. 36). While the study was considered helpful, the authors modified its methodology by following a systematic, epidemiological approach to medical injury (pp. 33-34).

ated with adverse outcomes, such as previous hospitalizations within a year, transfers to an intensive care unit, or deaths during hospitalization.[13] Records that failed the screening were then reviewed by two or more physicians, each of whom determined whether a medical injury had occurred, and, if so, whether the injury was due to negligence and, finally, the degree of disability caused by the injury (ranging from minimal to severe) (p. 37). To increase the reliability of physician judgments, which are often quite subjective, the Harvard researchers developed an adverse event analysis form ("AEAF") to assure unbiased judgments.[14] The doctors using the AEAFs were required to rank their confidence in the judgments they had made about causation and negligence.

To verify the validity of the study's findings, a sampling of hospital records was compared against tort claims files, on the assumption that the files would serve as a basis for determining whether information had been "concealed" in the hospital records. More than eighty percent of the adverse events and nearly seventy-five percent of the negligent adverse events were found to have been accurately identified from the hospital records alone.[15] The 31,000 medical records from which the researchers drew their data came from a cross-section of nonpsychiatric hospitals, "stratifying on the basis of three hospital variables: type of ownership, teaching status, and geographic region."[16] From a review of 30,195 records, 1278 adverse events were discovered; negligence caused 306 of these (p. 42).[17] Seventy percent of the patients who

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[13] *See* Henry H. Hiatt et al., *A Study of Medical Injury and Medical Malpractice: An Overview*, 321 NEW ENG. J. MED. 480, 483 (1989) (listing screening criteria utilized by researchers in searching through hospital records for negligence and causation of adverse events).

[14] Instead of the physician-lawyers which had been used in the California study, surgeons and internists were used to review the records for adverse events of negligence, thereby allowing the study to be used by health care institutions that had previously refused to rely on physician-attorneys for quality assessment (p. 38).

[15] *See* Troyen A. Brennan et al., *Reliability and Validity of Judgments Concerning Adverse Events Suffered by Hospitalized Patients*, 27 MED. CARE 1148 (1989) (describing methodology used by record reviewers in greater detail).

[16] *See* Brennan, *supra* note 8, at 481. The stratification included samples from teaching and nonteaching hospitals in both rural and urban settings, some of which were privately owned and others which were governmentally funded (p. 40).

[17] The Harvard group concluded that in New York in 1984, 3.7% of the patients hospitalized suffered adverse events and 27.6% of those were due to negligence (p. 42). *See* Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 321 NEW ENG. J. MED. 431 (1991) (summarizing results of Harvard study).

experienced adverse events incurred relatively short terms of disability. Based on study projections, approximately 3800 adverse events statewide produced permanent impairment resulting in a level of disability of up to fifty percent (p. 44). An additional 2500 patients suffered a severe or total disability and approximately 13,400 New York patients hospitalized in 1984 died as a direct result of medical treatment, fifty-one percent of them due to negligence. One chilling conclusion of the study was that "[t]wo-thirds of the injuries produced by grave negligence were fatal, six times the mortality rate for non-negligent iatrogenic injuries" (p. 45).

The authors independently analyzed several different aspects of the health care system to assess individual risk factors affecting injury rates. One conclusion was that patients over the age of sixty-five had an alarmingly high risk of sustaining medical injury (p. 45). Another finding was that the percentage of adverse events due to negligence was higher among African-American patients and those with an income below the poverty level.[18] Also, uninsured patients suffered a greater risk of negligent care than patients with medicaid or private insurance (p. 47).[19]

Hence, the "major risk factors for receiving poor quality care" (p. 47) were patient age and a lack of health insurance. Race, as a determining factor, became less significant when more sensitive methods were used to achieve greater statistical accuracy. Nevertheless, because African-Americans comprise such a high percentage of patients who lack health insurance coverage, they were among the patient group at greatest risk for medical injury and negligent treatment.[20]

The hospitals studied had a range of adverse events that varied from 0.2 percent to 7.9 percent of admissions, or an average of 3.2 percent (p. 47). The rates of adverse events caused by negligence, however, covered a far broader range, from a low of one percent to a shocking high of sixty percent, for an average of 24.9 percent (p. 47). Three hospital characteristics tended to influence

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[18] *Cf.* Helen R. Burstin et al., *Socioeconomic Status and Risk for Substandard Medical Care*, 268 JAMA 2383, 2385 (1992) (finding poor patients had significantly higher adverse event and negligence rates than all other income groups).

[19] *See* Joel S. Weissmann et al., *Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland*, 268 JAMA 2388, 2392 (1992) (stating uninsured patients have higher hospitalization rates than insured patients); *cf.* Burstin, *supra* note 18, at 2385 ("Payer status was not associated with *significant* differences in adverse event rates.") (emphasis added).

[20] *See* Burstin, *supra* note 18, at 2386-87 (summarizing study).

the risk of medical injury. First, higher rates of medical injury were found in university teaching hospitals than in affiliated teaching or nonteaching hospitals (pp. 48-49).[21] Second, urban hospitals had more adverse events than hospitals in rural areas of the state. Third, medium-sized hospitals had more adverse events than larger-sized ones (pp. 49-51).

Negligent adverse events were significantly higher in hospitals with a high percentage of minority patient discharges. University teaching hospitals and proprietary hospitals had lower incidences of negligence than the others studied. Negligent adverse event rates in hospitals with primarily minority admissions were thirty-seven percent, and thirty-five percent in government hospitals, as compared with only 10.7 percent in university teaching hospitals, and 9.5 percent in proprietary hospitals.[22]

Several medical specialties were also reviewed, and among them the treatment of newborns by pediatricians enjoyed the lowest rate of medical injury (0.5 percent) while vascular surgery suffered the highest (16.1 percent). Further, surgeons had higher rates of negligent medical injuries than internists (p. 53). Although only three percent of adverse events occurred in the emergency room, seventy percent of these were found to be due to negligence. Despite having the highest rate of adverse events (forty-eight percent), surgical treatment had a lower rate of negligence than nonsurgical adverse events (thirty-seven percent). Only eight percent of the adverse events found were caused by diagnostic errors, yet seventy-five percent of those errors were attributable to negligence.[23] Furthermore, adverse events caused by diagnostic work-ups posed a greater threat of serious traumatic outcomes than did other nonsurgical adverse events.[24] A majority of the nonsurgical adverse events were attributable to errors in

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21 *Cf.* Troyen A. Brennan et al., *Hospital Characteristics Associated with Adverse Events and Substandard Care*, 265 JAMA 3265 (1991) (reporting these findings).

22 *See id.* at 3267 ("The only factor significantly associated with an increased percentage of [adverse events] due to negligence was a large proportion of discharged minority patients.").

23 The authors note that diagnostic errors are the most difficult medical injuries to detect and also the most likely to go uncompensated in a no-fault plan (p. 150).

24 Forty-seven percent of adverse events from diagnostic work-ups caused death or permanent disability, compared with 35% serious disability for other non-surgical adverse events (p. 54).

medical management, one-half of which were deemed the result of negligence.[25]

The implications of the findings outlined in the third chapter of the book are profound. In 1984, almost 100,000 injuries occurred during hospitalizations in New York and one-quarter of those injuries were caused by negligence. If these results hold true for the entire U.S. population, there would be approximately 150,000 deaths each year resulting from medical injuries, more than one-half of which would be caused by negligence,[26] and approximately 30,000 people would suffer severe nonfatal injuries due to medical treatment (p. 56).

Although the study reveals that "disproportionate numbers of negligent injuries are inflicted on elderly and uninsured patients" (p. 58), these same individuals are said to be less likely to file lawsuits.[27] Since a significant number of negligent medical injuries are inflicted on those who are less apt to sue, the authors conclude that malpractice litigation may not be a sufficient deterrent against negligent care (p. 59). The researchers advocate, therefore, the development of "fail-safe systems" (p. 58) within the medical community to overcome human errors, such as the use of computers to prevent patients from receiving drugs to which they have a known sensitivity.

IV. THE TORT GAP: NEGLIGENT MEDICAL INJURIES THAT DO NOT RESULT IN CLAIMS OR SUITS

One justification offered for the proposals made by the Harvard Medical Practice Study is that the current tort-based system for compensating medical injury claims has failed. "[T]he real

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25 *See* Lucian L. Leape et al., *The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II*, 324 NEW ENG. J. MED. 377, 379-80 (1991) (asserting surgical errors were most common, followed by failure to take preventive measures and diagnostic errors, respectively).

26 Although medical malpractice figures may exceed the annual death rate associated with motor vehicle and workplace accidents, the authors contend that many of the individuals accounted for would have died from their medical conditions anyway (p. 55).

27 *See* Mark Sager et al., *Do The Elderly Sue Physicians?*, 150 ARCHIVES OF INTERNAL MED. 1091, 1093 (1990) (suggesting elderly are less likely to file malpractice suits despite greater exposure to adverse events caused by negligence). *But cf.* Edmond G. Doherty & Carl O. Haven, *Medical Malpractice and Negligence: Sociodemographic Characteristics of Claimants and Nonclaimants*, 238 JAMA 1656, 1657 (1977) (suggesting older patients of higher socioeconomic status are more apt to detect negative medical experiences, and therefore, to make claim or bring suit).

tort crisis may consist in *too few* claims," the authors assert (p. 62).[28]

Before arriving at this conclusion, the Harvard group reviewed a database of almost 68,000 medical malpractice claims filed with New York insurers from 1975 through early 1989. The authors' findings discredit an earlier study by the U.S. Government Accounting Office that reported the annual claims rate as one for every three practicing physicians in the state. The Harvard researchers found that in New York there were nine malpractice claims paid per 100 physicians for the year 1984 (p. 65), ten percent of which were filed later than four years after the date of the original injury. The annual frequency of malpractice claims rose steadily from 3200 in 1976 to 5400 in 1984. The claims filed against individual physicians, however, increased less dramatically because more claims were made against hospitals (p. 68). In 1984, the practice of bringing claims against multiple health care providers for damages arising from a single incident emerged. As a result, while only forty percent of claims arising from a single incident resulted in payment, one-half of the patient claimants received money for their injuries because of the multiple claims they asserted. (p. 68). In 1988, the average amount paid per successful claim more than tripled and median payments were over seven times their amount in 1976 (p. 68).[29]

Although almost one out of every eight doctors will be sued for medical negligence each year, the authors conclude that only one in every seven patients who suffered medical injury attributable to negligence will file a malpractice action (p. 69). After comparing the information from the insurance database on claims made in 1984 with the group's estimate of patients who suffered negligent medical injuries in that same year, the authors found that nearly eighty percent of the negligently injured patients who did not file a claim either fully recovered from their injuries within six

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[28] The California study and the National Association of Insurance Commissioners both found that for every 10 instances of medical negligence in California hospitals only one medical malpractice claim was made in the California liability insurance system (p. 62). Of the claims that were made, only 40% of patients ever received any payment through the legal system (p. 62). Consequently, only 4% of the total number of in-hospital torts in California resulted in compensation to the injured patient (p. 62).

[29] The authors explain that the real value of claims tripled from 1976 to 1988, at which time the average successful claimants were receiving about $225,000 for their medical injuries (p. 68).

months or were more than seventy years old when the injury occurred (p. 70).

Among the 151 hospitals involved in the Harvard study, only forty-seven claims were filed by hospitalized patients, more than one-half of which revealed evidence of either medical injury or medical negligence (p. 71). Therefore, "[e]xpressed in the form of ratios calculated from the sampling weights, the chances that a claim would be filed by a patient with an identifiable negligent injury was . . . only one in fifty" (p. 73).[30] The authors believe that this figure overstates the gap between instances of medical negligence and tort claims filed. In 1984, only about two percent of the patients who suffered a negligent medical injury actually filed a malpractice claim. The authors speculate that the probable ratio of negligence to claims, which they consider to be the true tort gap, is perhaps one in thirty. According to their estimates, there were thirty potential claims for every one actually made and 15 potential claims for each one actually paid, "because almost all valid claims made will eventually be paid" (p. 75).[31] The authors maintain that the financial and emotional burdens imposed on innocent physicians who are sued by patients with invalid claims, combined with the tremendous gap between negligently inflicted injuries and malpractice suits filed against health care providers, clearly demonstrate a pressing need for comprehensive tort reform (pp. 75-76). Despite the fact that a large portion of this gap consisted of only minor injuries where little or no financial loss was suffered, there was still "several times as many seriously disabled patients who received no legal redress for their injuries as innocent doctors who bore the burden of defending against unwarranted malpractice claims" (p. 76). The authors assert, therefore, that the legislative effort should emphasize the creation of a legal system that would be more accessible to victims of negligent medical treatment (p. 76).

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30 *Cf.* A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence, Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245, 250 (1991) ("[T]he civil-justice system only infrequently compensates injured patients and rarely identifies and holds health care providers accountable for substandard medical care.").

31 *See id.* at 249 (positing reasons for this startling low ratio).

V. EXPANDING REDRESS FOR MEDICAL INJURIES BY REDUCING DAMAGES

In their attack on the legal system's failure to redress all negligent adverse events, the authors compared the benefits and costs of malpractice litigation. They state that the "distribution of the insurance dollar seems misplaced: at most only modest scheduled benefits would be paid [under their proposal] for the nonfinancial losses stemming from iatrogenic injuries" (p. 80). The authors further assert that under the proposed no-fault system, costs would be reduced by excluding short-term disabilities from coverage and only compensating long-lasting, severe disabilities. Moreover, the additional costs attributable to medical injury would be paid only after the first six months of disability.[32] Prior to this time, payment of no-fault benefits would not be made, in order to avoid paying costs attributable to the background illness.[33] Furthermore, the authors advocate a change in the method of compensating lawyers since proof of negligence would no longer be a component of the system. Contingent fees, therefore, would no longer be cognizable as a method of attorney compensation. Rather, the authors intimate that attorneys would be paid pursuant to a plan similar to the one currently utilized in workers' compensation cases (p. 82).

The authors also assessed the financial feasibility of their proposal by estimating the losses for patients injured in 1984 and projecting their calculations to cover the remainder of the patients' lives (p. 85). Wage losses, employer-paid fringe benefits, and lost household production were accounted for in the estimation of lifetime losses that would be suffered by patients as a result of negligent medical treatment incurred in 1984 (pp. 85-87). Patients hospitalized in New York incurred overall costs of $21.4 billion from their initial illnesses and medical injuries.[34] Finan-

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[32] This six month ineligibility period would commence upon admission to the hospital because work-related sick leave payments and benefits from New York's temporary disability insurance plan would provide up to 20% of substitute income to disabled patients and their dependents (pp. 100-01).

[33] The authors contend that after six months, social security disability benefits would also become available for permanently and totally disabled patients; this ultimately would result in even greater savings for the no-fault system of compensation (p. 81). Additionally, the authors believe that New York's general temporary disability law would adequately compensate injured patients for the initial six months. *See* N.Y. WORK. COMP. LAW §§ 204-05 (McKinney 1993).

[34] This figure was comprised of all the elements factored into the group's estimate of projected lifetime losses suffered by patients due to negligent care (p. 92).

cial losses caused by medical injury alone constituted only a small proportion of the total costs while lost earnings comprised the highest cost attributable to medical injury (pp. 95-96). Most of the patients who experienced medical injuries had been employed before hospitalization.[35] Approximately ten percent of the patients either died in the hospital or soon after discharge. The most severe economic losses due to medical injury were concentrated in a small segment of the patient population,[36] and the largest component of total losses was due to the eighteen percent of injured workers who died because of a medical injury.

As noted earlier, although negligent injuries comprised only about one-quarter of the medical injuries, they were responsible for nearly one-half of the severe to fatal ones. Not surprisingly, the average economic losses suffered because of medical injury were much higher among the patients afflicted with negligent injuries even though those injuries constituted such a large proportion of the fatal injuries, which did not involve any long term medical costs (p. 97).

To further bolster their assertion that the tort liability system has failed, the authors point out that only about one-quarter of the hospitalized patients studied were fully reimbursed for any loss of wages they incurred after six months from the date of their admission. The other three-quarters incurred uncompensated losses averaging $70,000 apiece. In fact, the researchers aver, those patients who actually brought suit incurred higher levels of economic loss than patients who did not sue and those who sued received lower ratios of compensation for their losses. The authors assert that this finding strengthens their conclusion that "more malpractice suits are brought by patients without rather than with a negligent medical injury" (p. 101).[37]

Although they advocate a six-month waiting period before a patient would become eligible for no-fault benefits, the authors

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[35] Fifteen percent of those who received medical injuries and were alive at discharge never returned to work, three-quarters of them due to ill health. Sixty-three percent of the employees and 55% of the homemakers resumed their usual work within six months after entering the hospital (p. 92).

[36] Ninety percent of the lifetime wage losses were suffered by 21% of the workers, and 99% of the lost household production fell on 22% of the homemakers (p. 96).

[37] The authors found, however, that the legal system works effectively to separate the good claims from the bad, even if it cannot prevent unmeritorious claims from being filed. Additionally, the authors concluded that "the chances that any one doctor will be sued are far greater if negligent treatment has occurred than if it has not" (p. 75).

claim their proposal would not have an upper limit on the compensation an injured patient could receive.[38] They recommend a six-month waiting period to benefit those patients with the most serious injuries. This would be accomplished by allowing a recuperation period designed to determine if the patient suffered a medical injury or simply experienced the consequences of treatment.[39]

The authors believe their plan would have cost less (at $900 million) than their estimated cost of malpractice insurance for all doctors and hospitals in New York in 1988 (over $1 billion) (p. 104). The authors fail, however, to include in the projected figures for their proposal the expense of administering the program.[40] Nevertheless, they state the current malpractice system spends approximately fifty-five percent of every claims dollar on "legal administration" rather than on direct payment to victims (p. 106). One source of savings, the authors assert, would result from "the absence of litigation over the defendant's fault: reliance [would be] placed on a less-formal administrative determination of what caused the victim's injury" (p. 106). As an example, the authors point to the much lower administrative costs (twenty percent) associated with workers' compensation claims.[41]

The savings the authors seek to achieve by eliminating compensation for pain and suffering, which the authors contend presently accounts for fifty percent of the amount of tort awards (pp. 106-07), represents a dramatic departure from the author's paradigm, the Swedish plan, which not only pays "up to 100% for economic loss . . . [but also] sixty-eight percent . . . for non-economic losses."[42] Despite the omission of pain and suffering losses from their analysis, the authors attempt "to determine the potential

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38 Later in the book, however, the authors recommend a cap on wage losses of "80 percent of net lost earnings up to 200 percent of the state's average earnings level" (p. 151).

39 In an apparent concession to those who believe a six-month waiting period would operate as an undue hardship, the authors state that a two-month waiting period would be an acceptable compromise (pp. 102-03).

40 The "substantial additional allowance [that] must be made for the cost of administration" of the authors' plan is not included (p. 106).

41 *But see* Williams G. Johnson et al., *The Economic Consequences of Medical Injuries, Implications for a No-Fault Insurance Plan*, 267 JAMA 2487, 2492 (1992) ("With such an addition for administrative costs . . . the . . . figure [almost $900 million] stated earlier could reach to $1.5 billion, even with a 6-month deductible in place.").

42 ROSENTHAL, *supra* note 8, at 176-77; *see also* Walter Gellhorn, *Medical Malpractice Litigation (U.S.)—Medical Mishap Compensation (N.Z.)*, 73 CORNELL L. REV. 170, 194 (1988) (finding New Zealand's no-fault system pays lump-sums of up to

costs of a scheduled financial benefit for impairment of normal enjoyment of life" (pp. 107-08).

The authors would accomplish additional savings by having the plan function as a "secondary payor to direct health care insurance" (p. 107).[43] They claim that as an alternative to litigation, the plan would reduce costs by eliminating the expense and delay associated with judicial determinations of causation (p. 108). Furthermore, they see the supplementary function of the plan as compatible with the increasing use of collateral source statutes, which reduce tort awards by the amount of first-party insurance benefits received by the plaintiff.

The authors' calculated savings are arguably flawed. For instance, they fail to discuss the impact of subrogation and reimbursement rights that are commonplace in most health insurance contracts.[44] The authors admit, however, that if Medicare and Medicaid refuse to waive their present reimbursement scheme for payments made to tort victims who are covered by no-fault compensation, then the cost of the no-fault plan would increase by an estimated $250 million (p. 108). If a benefit is added for pain and suffering, the cost would become almost double the current expense for medical malpractice insurance. The authors, however, believe the added costs would be offset by the previous over-calculation in costs and a lower number of actual claims than is estimated.[45]

$17,000 for non-economic loss to individuals who suffer permanent loss or impairment of bodily functions and up to $10,000 for pain and suffering).

[43] The authors contend this factor is a major source of savings in cost estimates for no-fault compensation because health insurance covers 80% of medical expenses and disability insurance covers 20% of long-term lost earnings (p. 108).

[44] *See generally* 44 AM. JUR. 2D *Insurance* §§ 1794, 1815 (1982) (discussing subrogation).

[45] First, the authors offset the cost of pain and suffering with their calculation of benefits payable for lost household production (p. 108). They valued these benefits at the full earnings lost and projected the amounts over the life expectancy of the injured patient (p. 108). If there were any doubts, and there often were, they presumed that injury rather than illness was the source of a given disability (p. 105). But the authors now assert that a lower estimate is more realistic (p. 108). Second, the authors argue that since their no-fault plan is premised on compensation for all patient injuries and losses, the actual cost would be less than the proposed cost because a considerable number of valid claims are never filed (pp. 108-09). The authors attribute this nonassertion of claims to the inability of patients to identify medical treatment as the cause of their disabilities (p. 109).

It is ironic that the authors seek to encourage acceptance of their plan by acknowledging that it will function to inequitably exclude those patients it is intended to include. These patients are presumably victims of misdiagnosis, where it is even

The researchers further claim that no-fault is superior to the current tort system because of the sizeable gap between negligent injuries that result in the filing of a suit and those upon which no suit is brought (p. 147). Even if the gap did not exist, they argue, tort claims provide remedies for only a small fraction of medical injury victims—those whose injuries were caused by negligence (p. 6). The researchers suggest that an alternative to the current system of malpractice litigation is needed to prevent another precipitous increase in medical malpractice liability insurance premiums (pp. 1-2). However, no empirical data are cited to substantiate this assertion.

VI. The Deterrent Effect of Medical Malpractice Litigation

The Harvard group surveyed New York doctors to find out the way they reacted to the threat of suit and to determine the deterrent effect of malpractice litigation. Case records were reviewed to see whether tort suits resulted in fewer patient injuries. The authors preface this part of the study with an expression of doubt about the effectiveness of the tort system in fulfilling its role as a deterrent. They question whether the types of incidents in which tort remedies are applied can be effectively deterred, since the likelihood of a lawsuit is remote even in instances in which medical negligence has occurred. They point out that "in terms of absolute numbers more claims are filed against careful than against careless doctors" (p. 115). In addition, the protection provided by malpractice insurance prevents a direct financial deterrent effect from being imposed on negligent doctors because premiums have not been based on experience-rating, as is the case in the workers' compensation fields. Even if they were, the authors argue, malpractice claims are only an occasional event in the careers of most physicians, unlike workers' compensation, under which many claims are filed annually and a merit rating system functions more effectively. They add:

> This critique is not directed against liability insurance itself: That institution serves to protect the doctor from possibly crushing damages as a result of a momentary inadvertent mishap and

more difficult to ascertain whether an adverse event has occurred. This conflicts with the authors' assertion that physicians might help to identify iatrogenic injuries that will constitute valid claims (*see* p. 145).

> also guarantees that the patient who has been hurt will find a source of funds to pay the damage verdict won in the courtroom.

(p. 114). They believe, however, that the insurance buffer does reduce the deterrent effect of the tort system.[46]

The first part of the study, focusing on deterrence, surveyed the views of New York physicians on the effects of malpractice litigation generally, and on the risk of being sued and bearing the costs and consequences of such litigation (pp. 117-31).[47]

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[46] The authors do not suggest that the existence of any insurance scheme necessarily deprives the insured of incentives to act cautiously (p. 114). Instead, the cost of insurance premiums could be pegged to the number of claims brought against an insured in the past (pp. 114-15). The use of this so-called "experience rating" would incorporate the deterrent effect in the insurance system and encourage careful medical practice. Such a program has been successfully used in fields such as workers' compensation but has not been applied to medical malpractice claims because such claims are less frequently asserted against individual physicians (pp. 114-15).

[47] The two methods used to gather data were written questionnaires and personal interviews (p. 117). The questionnaires were sent to a large population of doctors who were differentiated by the following criteria: practice specialty, geographic location and claims history (p. 117). The specialties studied were ranked according to risk. Internal medicine and associated fields were considered low risk; general surgery and associated specialties were deemed medium risk; and orthopedic surgeons, neurosurgeons and obstetricians were deemed high risk (p. 117). The geographic areas of New York from which the doctors were drawn included Long Island and upstate counties. The doctors were divided into two groups for claims history information: those who had a claim filed against them since 1975 and those who had not (pp. 117-18).

Of the 1823 questionnaires sent, only 739 were completed and returned, which amounted to a 41% response rate (p. 118). The respondents tended to be older, male (92%), board certified (65%) graduates of U.S. medical schools (73%) who had been sued for malpractice at least once since 1975 (55%) (p. 118).

The information sought from the doctors fell into four categories. The first was the subjects' estimate of the risk of suit (p. 118). This estimate was compared with information gathered on claims which were actually filed in order to obtain a true risk of suit. Next, the physicians were asked about the expenses they incurred in malpractice suits, such as days lost from medical practice, out-of-pocket expenses for personal counsel and direct payments not covered by liability insurance (p. 118). Third, the doctors were questioned about variations in their practice methods over the last 10 years. In particular, they were asked whether they ordered more tests, spent additional time explaining to patients the risks of treatment, allocated greater time to maintaining detailed paperwork or saw fewer patients as a result of the risk of suit (pp. 118-19). Finally, the subjects were asked to compare the effects of malpractice litigation on the maintenance or enhancement of quality medical care with those of other quality assurance methods such as peer pressure, review of medical journals, or continuing medical education (p. 119).

The subsequent personal interviews yielded qualitative data to supplement the results of the questionnaire distribution. Ninety-minute interviews were conducted with 47 doctors who responded to the questionnaires (p. 119). They had been questioned about their observations of the impact of litigation on their practice, their feelings toward quality assurance programs and, if they had been sued, their beliefs as to

The second part of the deterrence aspect of the study sought to determine whether the threat of litigation resulted in safer medical care.[48] The physician survey indicated that although fewer medical malpractice suits are brought than the doctors estimated, the inflated prospect of litigation exerted a deterrent effect on the provision of negligent medical care by physicians (pp. 124-26). The doctors surveyed also overestimated the risk that malpractice claims will be brought against them.[49] However, although they overstated the danger of claims and suits, they underestimated the risk that a physician will negligently injure a patient.[50]

The financial cost of lost earnings and legal expenses incurred by physicians presents another deterrent, even though a physician has malpractice coverage.[51] However, the financial burden is

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why they had been sued. Furthermore, the physicians were presented with patient disability scenarios, which varied in their degree of adverse events and negligent adverse events, to ascertain their attitudes toward issues of causation and negligence (p. 119). *See also* Ann G. Lawthers et al., *Physicians Perceptions of the Risk of Being Sued*, 17 J. HEALTH POL., POL'Y AND L. 463 (1992) (discussing this part of study further).

48 The study group used data drawn from the previous study of medical injuries, claims reports filed with insurance companies and litigation information from the hospitals (p. 120). Claims filed in 1983 were reviewed to determine whether they influenced treatment practices and patient injury rates in 1984 (p. 121). Studying 27,574 admissions in 49 hospitals, the authors identified 843 adverse events, 189 of which were found to be due to negligence. They used this data to ascertain the likelihood of negligent injury per iatrogenic injury (pp. 121-22). The study group then used the data on injury and litigation rates to discern the rate of claims per negligent injury (p. 122). This final rate was intended to test the assumption that under the tort system a higher rate of malpractice claims translated into a lower rate of negligent medical injuries suffered. If that premise stood true at the end of their study, it would demonstrate the deterrent effect of the tort system (pp. 73-76).

49 The doctors surveyed overestimated the annual number of malpractice claims by approximately three times its true rate (p. 124). Physicians in the lower risk specialties and geographic regions in upstate New York made greater overestimations than those in the higher risk specialties and regions in downstate New York. Furthermore, when asked about the likelihood of a lawsuit arising from patient injury and physician negligence, the former group of doctors believed that 45% of adverse events and 60% of negligent adverse events led to malpractice claims, when actually 13% of negligent injuries and less than 4% of both negligent and non-negligent injuries produced actual claims (p. 125).

50 The doctors surveyed overestimated the number of suits per iatrogenic injury by 10 times. The authors attribute this excess, in part, to the pronounced reluctance of doctors to label treatment decisions as negligent (p. 125).

51 Physicians who were sued lost a *median* of three to five work days per malpractice case, with an overall *average* of six days (p. 126). Since at the time of the study, doctors in New York earned an average of $1,100 a day, they lost approximately $7,000 per claim. Moreover, out-of-pocket expenses increased the cost of litigation for

considered small compared to the emotional trauma involved in a public legal attack upon a physician's performance and competence (p. 126).

The survey also revealed the impact malpractice litigation has had on the medical profession. The threat of legal proceedings increased the likelihood that doctors would order more tests, reduce the number of patients seen, and limit the types of procedures undertaken. Yet doctors denied that litigation has a strong influence on improving the quality of medical care (p. 126). Rather, they reported that continuing medical education, the review of medical journals, and peer group discussions had a greater influence than litigation in improving the quality of medical care (pp. 127-28). Moreover, the increased time spent on paperwork was seen by the authors to be a result of heightened patient care regulation by hospitals, insurers, and government agencies (p. 127).

The conclusion reached by the authors in the second part of the study is that malpractice litigation has a deterrent effect on patient injuries (p. 129). The authors found that tort litigation reduces both the negligent injury rate and the combined negligent and non-negligent injury rate.[52] However, the authors believe several problems with their findings[53] warrant their rejection as a basis for policy making.[54] Nonetheless, the authors' determina-

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those doctors who hired private counsel and for those who paid their own money to settle claims (p. 126).

52 The rate of negligent injury of 0.89% of admissions rose to 1.25% of admissions if there were no medical malpractice claims brought. The overall injury rate (negligent and non-negligent alike) of 3.3% of hospital admissions rose to 3.7% without medical malpractice claims activity. Thus, the level of tort litigation reduced the negligent medical injury rate by 29% (from 1.25% to 0.89%) and the overall negligent and non-negligent medical injury rate by 11% (from 3.7% to 3.3%) (p. 131).

53 First, the authors qualify their findings by stating that they lacked a sufficiently large body of data to satisfy statistical standards of proof (p. 129). They expressed concern that their presented correlation might be coincidental rather than causal. The authors contend the great public interest involved and the absence of evidence to the contrary justify the assumption that the results are sufficiently valid to initiate practical policy-making to address this urgent problem (p. 131). Second, the authors acknowledge that the impact of tort claims on medical injuries may be greater than they estimated since they used injury statistics from several hospitals with minimal claims exposure (p. 132). These hospitals and the doctors employed there had a lower than average risk of being sued (p. 132).

54 First, the authors denounce the findings because they fail to scientifically determine "the overall social cost" (p. 133) of obtaining the injury prevention effect. Interestingly enough, they did not express a corresponding concern over their inability to determine the overall social costs of abandoning the current tort system.

tion that malpractice litigation changes doctors' behavior has considerable merit. Although health care costs may rise because of increased defensive testing and procedures, there are notable benefits such as the measures taken to prevent injuries and the greater amount of time spent with patients to discuss treatment options (pp. 133-34).

As a further step, the authors sought to determine the optimal mix of increased tort prevention and increased medical expense. They applied the so-called "Danzon test," which maintains that the tort system would pay for itself if it reduced negligent injury rates by twenty percent or more.[55] Since the authors estimate that negligent injuries are reduced by twenty-nine percent (p. 131), tort litigation meets the test, particularly since the injury prevention estimates in the study are low (p. 134).

VII. THE PROPOSAL: ENACTMENT OF A VOLUNTARY NO-FAULT PLAN, OSTENSIBLY WITH THE PATIENT TO CHOOSE—TORT OR NO-FAULT

"[S]piraling and excessive levels of litigation and damage awards" (p. 136) have the medical profession clamoring for the reform of medical malpractice litigation.[56] The Harvard group con-

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Second, setting aside cost considerations, the authors could not demonstrate that the current system prevents more injuries than other forms of medical liability (p. 133). In fact, similar studies in the area of automobile insurance have indicated that a no-fault compensation scheme increases the number of total accidents. *See* Elisabeth M. Landes, *Insurance, Liability, and Accidents: A Theoretical and Empirical Investigation of the Effect of No-Fault Accidents*, 25 J.L. & ECON. 49, 61-62 (1982) (discussing that no-fault insurance produces "both an economically and statistically significant increase in fatal accidents").

[55] *See* PATRICIA M. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY 226 (1985). This test is based on the premise that increased litigation expenses are justified only if there is a proportional increase in deterrence benefits. *Id.* Employing a 1974 estimate that 10% of negligent accidents result in a claim and 4% of these result in compensation, the author concluded that a 4% reduction in the rate of negligent injury would justify the costs of the tort system. *Id.* From this, the author concludes that a 20% decrease in the negligent injury rate is required to justify malpractice litigation. *Id.*

[56] State legislatures have been pressured to make it more difficult to bring medical malpractice claims, to win them, and to be fully compensated (p. 136).

Other proposals have been even more draconian. A plan devised by the American Medical Association ("AMA") would take medical malpractice cases away from juries and judges entirely and have them decided administratively as part of the medical disciplinary process. *See* PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 114-32 (1991) (discussing AMA's plan); Brennan, *supra* note 8, at 451-55 (discussing benefits and problems of AMA's plan). Private contracts entered into by doctors and patients have been advocated as a means of by-passing the judicial process and resolving tort

cedes that the basis for the current pressure for malpractice reform—the contention that litigation rates are rising precipitously—is in reality a myth (p. 137). Their study demonstrates that "the underlying assumption that too many groundless malpractice suits are initiated is unfounded" (p. 137).

Sharing this view, the authors are critical of the tort system because "[n]ot too many, but rather too few suits were brought for the negligent medical injuries inflicted on patients" (p. 139).[57] They argue that since only a minority of the claims filed are based on negligence, most cases are needlessly swept into the tort system.[58] Moreover, they asserted that malpractice litigation does not fully compensate injured parties because a large part of the money recovered is spent on paying attorney's fees, reimbursing financial expenses already covered by other insurance, and compensating the patient for pain and suffering experienced in earlier years.[59]

As an alternative to the tort system in the health care field, the authors support the use of a model based on workers' compensation plans (p. 145). Strict liability would be imposed on hospitals for injuries to patients that are proven to result from medical

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liability (p. 136). The proposal ultimately espoused by the authors of this book is a no-fault plan to compensate all victims of medical injury, regardless of whether the injury resulted from negligence (p. 145). This approach has been adopted in Sweden and New Zealand, and the authors use the two plans as examples of the potential for the success of no-fault in this country.

[57] According to study findings, one malpractice suit was filed in New York for every 7.5 patients who suffered a true negligent injury (p. 139). Approximately one out of two tort claims were ultimately paid. This translates into one paid malpractice claim for every 15 negligent injuries inflicted in hospitals. If one were to focus on claims involving serious injury to patients under 70 years of age, the ratio is more dramatic at one claim paid for every three negligent injuries (p. 139).

[58] However, the authors acknowledge that once a case had been filed, discovery procedures permit patients and their attorneys to make more accurate judgments about the merits of their claims (p. 140). One report cited by the authors confirms the ability of malpractice litigation to filter out bad claims and to award damages, Henry S. Farber and Michelle J. White, *Medical Malpractice: An Empirical Study of the Litigation Process*, 22 RAND J. ECON. 199 (1991). *See* Mark A. Taragin et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 ANNALS INTERNAL MED. 780, 782 (1992) (stating that in medical malpractice cases studied, "our data suggests [sic] that inappropriate payments are probably uncommon"). The study group, however, still criticizes the discovery process because it creates a "sizeable financial and emotional burden on doctors and their insurers simply by sweeping them into lawsuits that arose on account of mistaken judgments made by patients' lawyers" (p. 140).

[59] The authors assert that if justice demands that insurance money be used for the pressing needs of the victims, the tort system seems to fail (pp. 141-42).

care (p. 19). This system would compensate only tangible financial losses—"the types of loss that insurance theory and practice demonstrate are best suited for such redress" (p. 145). The authors disparage the current system's purported tendency to award damages for "virtually all imaginable forms of pain and suffering" (p. 145). The compensation scheme they envision would cover only medical injury victims with long-term disabilities who are not protected from "catastrophic losses" (p. 145) by other forms of medical or disability insurance. "In this respect, the system would function analogously to the collateral source offset provision that has now emerged in the malpractice regimes in a number of states, including New York" (p. 145). Instead of investing a great deal of time and money to determine culpability, the plan's compensatory mechanism would be triggered by proof that a patient's injury was medically caused.[60] The proposed system would use either self-insurance or experience-rated insurance, both of which would directly link medical injuries to physician costs (p. 148).[61]

The Harvard group, however, anticipates several major problems with the no-fault approach. First, they expect more marginal claims and, therefore, higher costs because the need to prove negligence would no longer exist (p.149). Second, the authors admit that pure no-fault compensation for medical injury is not possible because identifying one essential category of medical injury—those caused by failure to diagnose or to recommend proper treatment—often depends on whether the physician took appropriate steps during diagnosis and treatment (pp. 149-50). A third concern is that hospitals, instead of adopting more precautionary measures, will simply turn away high-risk patients rather than risk liability for all injuries (p. 150). As a prelude to adopting a no-fault compensation scheme, the authors advocate an elective approach because it would permit a study of the way the plan operates before it is mandated in all institutions (p. 151). Under an elective approach, the no-fault plan could be compared with the

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[60] The authors optimistically suggest that physicians might help in making the determination of whether an injury was iatrogenic (p. 145). This notion of a mutually beneficial relationship between physician and patient already exists in Sweden, where it is reported that doctors frequently encourage patients to file claims and help complete forms. *See* Brennan, *supra* note 8, at 457 n.132 (discussing administration of no-fault plan in Sweden).

[61] Proponents of the plan argue that imposition of liability for a substantial number of small awards on a health care institution where an injury has taken place, rather than holding individual doctors responsible, would do more to prevent medical injuries than would use of a non-merit rated insurance scheme (p. 148).

coexisting tort system to determine the advantages and disadvantages of both.[62]

To implement the elective no-fault compensation scheme, the authors recommend that states begin by enacting a statute authorizing hospitals and health care organizations to offer patients administrative compensation for medical injuries in return for a waiver of tort liability. Patients would be informed of the tort rights they would surrender and the no-fault benefits they would receive. The legislation would mandate that benefits include out-of-pocket medical expenses, eighty percent of net lost earnings (up to 200% of the state's average earnings level) and "specified payments for loss of enjoyment of life associated with certain physical impairments" (p. 151). The legislation would impose standard filing procedures to ensure accessibility, neutrality, and due process, and would mandate the creation of effective quality assurance programs for participating hospitals to establish, among other things, accountability for medical injuries.[63]

VIII. PIPE DREAMS?

In a sweeping attack, the New York State Bar Association offered a comprehensive critique of the Harvard group's study.[64] The most damning criticism leveled by the bar association report was that no-fault would marginally increase the number of injured patients entitled to compensation by drastically restricting the amounts recoverable. Even then the expense of no-fault would far exceed what is spent under the tort system. One of the authors of the Harvard study has acknowledged elsewhere that no-fault would be more expensive.[65]

The authors have not made a persuasive case for no-fault medical injury compensation. Few doctors can be expected to support the plan, since under it they become guarantors against any number of unfortunate happenstances that can occur in the non-

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62 "That last value is especially important for those who believe, as we do, that governments should know something about the real world of medical injury and malpractice litigation before they enact reforms that profoundly affect the fates of patients, doctors, and lawyers for decades to come" (p. 152.).

63 Hospital peer review committees would be immune from antitrust laws and thus free to suspend the practice privileges of careless physicians (p. 151).

64 *See* Maxwell J. Mehlman, *Saying 'No' to No-Fault: What the Harvard Malpractice Study Means For Medical Malpractice Reform, in* N.Y. STATE BAR ASS'N., SPECIAL COMMITTEE ON MEDICAL MALPRACTICE (Jan. 1991).

65 Brennan, *supra* note 8, at 458 ("No-fault would undoubtedly cost more than torts . . . .").

negligent treatment of patients. Under the authors' plan, insurance premiums would be based on the number of adverse events among a health care provider's patients. Thus, doctors and hospitals will be tempted to turn down critically ill patients whose medical conditions involve riskier and more intensive treatment. This is so because doctors and hospitals cannot avoid the danger of a non-negligent accident occurring in their care. There is a significant risk, therefore, that they will be subjected to higher insurance premiums and closer scrutiny by peer review and accreditation committees.

Under the scheme proposed in the Harvard study, hospitals would present entering patients with a contract requiring them to choose between no-fault or tort in the event a medical injury occurs. Such a scheme is impracticable for several reasons. First, this type of contract would rapidly deteriorate into one of adhesion. Second, few patients would fully understand the choice they were making. Third, given the restrictions that would be necessarily placed on eligibility for benefits, many patients choosing no-fault would find themselves ineligible for recovery in the event they suffered medical injury. Yet they would have waived their option to pursue a remedy under the tort system.

Aside from the impracticability of the no-fault system, the authors also overstate the failings of the tort system. For example, they contend that medical malpractice insurance rating methods do not take claims history into consideration, and that even if an experience-rating system were used, there would be no significant change in the level of insurance premiums paid by doctors. The empirical evidence, however, supports a contrary conclusion.[66] In fact, the medical profession itself resisted implementation of experience rating,[67] and most states, including New York,[68] now require insurance companies to use merit rating for physicians.

The authors spent almost $4 million to produce their report, submitted more than a year late, to justify their recommendations for a no-fault plan. Their medical data are useful in the continuing debate over health care, but their theoretical discussion on the

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[66] *See* C. E. Phelps, *Experience Rating in Medical Malpractice Insurance, in* RAND, INSTITUTE FOR CIVIL JUSTICE, P-5877-1, (June 1978); J. E. Rolph, *Some Statistical Evidence on Merit Rating in Medical Malpractice Insurance, in* RAND, INSTITUTE FOR CIVIL JUSTICE, N-1725-HHC (June 1981).

[67] *See* Patricia Munch, *Causes of the Medical Malpractice Insurance Crisis: Risks and Regulations*, RAND, INSTITUTE FOR CIVIL JUSTICE, P-5766 (Dec. 1976).

[68] N.Y. INS. LAW § 2343(d) (McKinney Supp. 1995).

merits of the two systems of compensation is too narrow. For instance, the authors' dismissal of the tort system as a meaningless remedy is cursory and omits much of the data that show the tort system functions fairly effectively. In addition, the authors devote little attention to proposals that would make the tort system more responsive, streamline access to the courts, or make courts less expensive to utilize. For instance, although the authors conclude that screening panels do little to aid the tort system in functioning effectively (pp. 8-10), they do not advocate the repeal of laws requiring presuit panel review. They decry the long delay between the time of injury and resolution of claim (p. 5), yet there is no mention of feasible means for shortening this delay.

The medical profession is generally seen as having a "circle the wagons" mentality when it comes to malpractice suits, with stone-walling and nondisclosure suggested as means of preventing cases from being pursued.[69] The book reinforces that perception by noting that hospitals participating in the study insisted that patients not be advised whether an accident had occurred or whether a negligent injury had been inflicted.[70] Furthermore, the authors' recommendations have come at an inopportune time, since insurance premiums seem to be leveling off from the dramatic increases of the 1970s and 80s.[71]

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[69] *See* Nathan P. Couch, et al., *The High Cost of Low-Frequency Events: The Anatomy and Economics of Surgical Mishaps*, 304 NEW ENG. J. MED. 634 (1981).

> The forces that could help to reveal and control epidemiologic sources of error tend to go into hiding when a malpractice suit or an adverse judgment in a malpractice suit is the only known outcome of a search for the cause of error. If we are to neutralize the pernicious and stifling influence of malpractice litigation, we must find an acceptable legal safeguard.

Id. at 637.

[70] *See supra* note 1 and accompanying text. *But see* Troyen A. Brennan, *Ethics of Confidentiality: The Special Care of Quality Assurance Research*, 38 CLINICAL RES. 551 (1990). Brennan concludes that "[t]he goal of better quality care is best served by limiting litigants' access to . . . [research] records." *Id.* at 556.

[71] *See* Brian McCormick, *'93 Insurance Rates Seen as Stable*, AMERICAN MEDICAL NEWS, June 21, 1993, at 22 (noting data released by St. Paul Fire and Marine Insurance Co. indicate frequency of malpractice claims decreased from 14.3 per 100 physicians in 1992); *see also* Milt Freudenheim, *Dealing in Myths on Malpractice*, N.Y. TIMES, Oct. 13, 1992, at D2 (stating claims decreased from 17.9% in 1985 to 13.9% in 1991). Although the New York State Superintendent of Insurance approved a 14% increase in malpractice insurance rates in 1993, this was the first increase after four years of declining rates. Kevin Sack, *Rise Granted on Insurance for Doctors*, N.Y. TIMES, July 27, 1993, at B1, B6.

CONCLUSION

The authors do not demonstrate a willingness to consider the tort system as part of a broader network for compensating the victims of injuries. Every negligent medical injury that did not result in a claim is seen by them as a failure of the tort system, rather than simply an exercise of independent choice by the injured patient. At its core, the no-fault proposal espoused by Professor Weiler and his colleagues can be seen more as a reflection of the medical profession's desire for autonomy, free from hectoring lawyers, uncomprehending juries, and burdensome insurance premiums, than as a plan for equitable patient compensation, improved accident deterrence, and quality medical care. Although the tort system clearly has its faults, the authors did not give it its day in court, and have not effectively compared the merits of the two systems.

In a report on an earlier study of why people forego their right to sue for medical negligence, another researcher mused:

> [W]e may have inaccurately or incompletely characterized the malpractice crisis. The crisis may be the high level of iatrogenic illness or injury for which people receive no compensation. Or it may be a crisis of confidence and credibility of physicians and health care institutions. Or the crisis may be that personality or attitudinal barriers prevent the "right" cases (those which involve the most egregious errors or the most serious and enduring consequences) from coming to trial, while those which have less serious consequences do. Whatever the crisis or crises of medical malpractice and malpractice insurance, there is no evidence from these data that it is a crisis of consumers' or lawyers' avarice, vindictiveness, or greed.[72]

It seems the authors of this book would not agree with Dr. Meyers' position, since the implicit slant of their book is to the contrary, and their proposal is weighted heavily against lawyers and the tort system. In the final analysis, it does not favor either the providers or the consumers of medical services. The Harvard Medical Practice Study has yielded information that will help fuel the health care debate, but the plan for a no-fault alternative should be rejected. No-fault, in New York or elsewhere in the

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[72] Allen R. Meyers, *'Lumping It': The Hidden Denominator of the Medical Malpractice Crisis*, 77 AM. J. PUB. HEALTH 1544, 1547 (1987).

United States, cannot effectively replace the tort system without enormous disruption, expense, and, perhaps worst of all, inequities. Despite the scholarly work done by the authors, no-fault medical injury compensation should remain a pipe dream.